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STEVEN K BUNTING PC

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FORM 3-A

Send original and 4 copies to
Workers' Compensation CourtWORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918**FILED**

MAR 19 2007

WORKERS
COMPENSATION COURT
TULSA

IN THE MATTER OF THE DEATH OF (deceased employee):

Eleazar Torres

Name of Claimant (individual filing claim)

Amalia Diaz

Name of Employer

CINTAS

Court Use Only

☒ Please check appropriate box
☐ I. Original Filing
☐ II. Amends Previously Filed Form 3-A
 (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

CLAIMANT'S FIRST NOTICE OF DEATH AND CLAIM FOR COMPENSATION

COURT CLAIM #

2007-03253 A

NOTE: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405) 522-8760 or (800) 522-8210.

(Please type or print)

DECEASED EMPLOYEE NAME (Last, First, Middle): Torres, Eleazar		Social Security #: 561-41-0756	Phone: (918) 838-3861
Mailing Address (include City, State & Zip): 413 S. 78th E. Ave. Tulsa, OK 74112		Date of Birth: 8-23-1960	Age: 46 Sex: Male
Occupation: Auditor	Was deceased employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>		Average Weekly Wage: \$494.00

Claimant's Name (Last, First, Middle): Amalia Diaz		Phone: (918) 838-3861
Mailing Address (include City, State & Zip): 413 S. 78th E. Ave. Tulsa, OK 74112		Relationship to Deceased: SPOUSE

Date of Accidental Injury: 6 Mar. 2007	Time: AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	Place of Injury: City/County/State Tulsa, Tulsa, OK
Date of Death: 6 Mar. 2007	Time: AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	Place of Death: City/County/State Tulsa, Tulsa, OK
Nature of Injury: Death		Body part(s) injured:
Describe activities when injury occurred, with details of how event occurred. Include object or substance which directly injured deceased. Unknown		
Cause of death (normally shown on Death Certificate)		Has deceased filed a claim for compensation regarding this accident? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

Employer: Cintas	Federal ID#	Telephone:
Complete Mailing &/or Street Address:	City	State Zip

Has a personal representative been appointed for the estate of the deceased? YES ☐ NO ☒ If so, state name and address below.

List names, relationships, addresses and dates of birth of all heirs at law of deceased and of any other person who actually depended upon deceased at the time of death. (on the reverse side)

I declare under penalty of perjury that I have examined this notice and claim, and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Name of claimant's attorney if represented:

Type or Print Name of Attorney: J. L. Franks	OBA#
Mailing Address: P. O. Box 799	
City: Tulsa	State: OK Zip: 74101
Telephone #: (918) 584-4724	

Upon filing this Notice of Death And Claim For Compensation, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to Section 19 of Title 76 of the Oklahoma Statutes, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

Signed this 16 day of March, 2007

